STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 16,746
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the decision by the Department of PATH denying her coverage under Medicaid for a partial posterior (mandibular) denture. The issue is whether the Department's regulation prohibiting coverage for all partial dentures is in violation of federal law and regulations governing the Medicaid program. In lieu of an oral hearing the parties have filed a written stipulation of facts and legal arguments. The following findings of fact are based on the parties' written submissions.

FINDINGS OF FACT

1. The petitioner is a seventy-one-year-old Medicaid recipient. In July 2000 the petitioner requested Medicaid coverage for a partial posterior denture.

2. Accompanying the petitioner's request was the following statement from her dentist:

> As (petitioner's) dentist, I am advising that she have a complete maxillary (upper) and a mandibular (lower) partial denture. She has #22 through #27 (cuspid

> to cuspid) on her lower arch. These are quite healthy and I would expect her to have these teeth the remainder of her life.
>
> It would be a disaster to have to extract these existing teeth, but rather use these teeth to stabilize her partial and give her much more biting power. I will charge (petitioner) the same fee for a mandibular partial as a complete denture.
>
> Please consider helping this patient out, she has no posterior teeth to chew her food.

3. Also accompanying the petitioner's request was the following statement from her treating physician:

> (Petitioner) sent an authorization for release of information in regards to her medical condition. As I understand, it has been recommended that she get a partial denture but apparently Medicaid will not cover this expense until all her teeth are extracted. Certainly, a denture would be of benefit to (petitioner) as she has had difficulty eating and weight loss over the recent months. I think it is medically unnecessary and potentially dangerous to extract good teeth and she should get the partial denture that is medically necessary. I hope Medicaid covers the appliance that is medically indicated.

4. There does not seem to be any dispute in this matter that without a partial denture the petitioner is unable to chew food. It is clear from the above medical providers' statements that the petitioner's medical need for a partial denture, from the standpoint of being able to chew food, is at least as great as if she were seeking a full denture.

5. There also appears to be no dispute that in many cases it is less costly for recipients to undergo oral surgery

to remove any remaining teeth and be fitted with full dentures than it would be to provide them with partial dentures.

ORDER

The Department's decision denying the petitioner Medicaid coverage for a partial denture is reversed.

REASONS

The Vermont Medicaid regulations allow for limited dental service for recipients age 21 and over. Medicaid Manual (MM) §§ M621 et. seq. Current Department policy is to allow Medicaid coverage for adults only for full or "complete" dentures. MM § M621.3. "Oral surgery for tooth removal" is also a covered service under M621.3.[1] Partial dentures are not covered. They are included, as follows, in MM § M621.6 under "non-covered services":

> Unless authorized for coverage via M108, services that are not covered include: surgical placement and restoration of dental implants; cosmetic procedures and certain elective procedures, including but not limited to: bonding, sealants, periodontal surgery, comprehensive periodontal care, orthodontic treatment, processed or cast crowns, bridges, and partial dentures.

[1] Prior approval is required for most adult dental services (M621.5) and there is an annual cap of $475 on all covered adult dental services (M621.4). Neither of these provisions is at issue in this matter.

Before reaching the issue of whether the above prohibition on partial dentures is consistent with federal law it must be determined whether the petitioner meets the criteria for coverage under any other existing provisions in the state regulations. Pursuant to M621.6, above, the petitioner initially requested, and was denied, coverage for a partial denture through the Department's M108 process.

MM § M108 is a recently enacted provision under which the Commissioner of PATH has the discretion to grant exceptions to denials of coverage based on extraordinary circumstances and cost-effectiveness. M108 includes the following provisions:

> Any beneficiary may request that the department cover a service or item that is not already included on a list of covered services and items. . . [T]he following criteria will be considered, in combination, in determining whether to cover the service or item for the individual and/or to add it to the list of pre-approved services or items. . .
>
> 1. Are there extenuating circumstances that are unique to the beneficiary such that there would be serious detrimental health consequences if the service or item were not provided?
>
> 2. Does the services or item fit within a category or subcategory of services offered by the Vermont Medicaid program for adults?
>
> 3. Has the service or item been identified in rule as not covered, and has new evidence about efficacy been presented or discovered?
>
> 4. Is the service or item consistent with the objectives of Title XIX?

5. Is there a rational basis for excluding coverage of the service or item? The purpose of this criterion is to ensure that the department does not arbitrarily deny coverage for a service or item. The department may not deny an individual coverage for a service or item solely based on its cost.

6. Is the service or item experimental or investigational?

7. Have the medical appropriateness and efficacy of the service or item been demonstrated in the literature or by experts in the field?

8. Are less expensive, medically appropriate alternatives not covered or not generally available?

9. Is FDA approval required, and if so, has the service or item been approved?

10. Is the service or item primarily and customarily used to serve a medical purpose, and is it generally not useful to an individual in the absence of an illness, injury, or disability?

In this case, in a decision dated September 13, 2000, the Commissioner denied the petitioner's request for M108 coverage primarily on the basis of criterion #1, above--i.e. that the petitioner's request presented no "unique" circumstances or "serious detrimental health consequences".

Based on the medical evidence the petitioner has submitted, see supra, it cannot be concluded that the petitioner has demonstrated that serious detrimental health consequences will occur if she does not have dentures, either full or partial. Her doctors have stated that she needs

dentures to chew--the same reason that presumably forms the basis for most recipients who are allowed Medicaid coverage for full dentures (see infra). However, the petitioner has not shown that her overall health will significantly deteriorate if she does not have dentures. It is not at all clear from her doctor's statement (supra) that the petitioner's recent weight loss is the result of not having dentures.[2] Therefore, based on the medical information submitted, it cannot be concluded that the Commissioner abused her discretion in denying the petitioner coverage for a partial denture under M108.[3]

It must be concluded, however, that an abuse of discretion from the standpoint of rulemaking occurred when the Department imposed a blanket ban on adult coverage for partial dentures while allowing coverage for full dentures. Because the Department's regulation denying coverage for partial dentures is not legitimately related to the medical needs of

[2] There is an indication in the record that the Department attempted but was unable to obtain further information from the petitioner's doctor linking any serious health problems to the lack of dentures.

[3] The Commissioner also found that the denial of partial dentures had a "rational basis" under criterion #5, supra, in that the Vermont legislature had imposed this limitation. Although this conclusion is, at best, dubious (see discussion, infra), in the absence of severe detrimental health consequences it cannot be concluded that it amounted to an abuse of discretion under M108.

recipients, it is concluded that it is invalid under federal law.

Under federal statutes, all states are required to provide Medicaid to recipients within certain broad categories of medical assistance. See 42 U.S.C. §§ 1396a(a)(10) and 1396d(a). In addition, states may elect to provide certain "optional services". Id. Dental services for adults is one such optional service. See 42 U.S.C. § 1396d(a)(12); 42 C.F.R. § 440.100(a). Vermont has chosen the option of providing dental services to adults. While states are allowed wide latitude in determining the extent of any optional medical services offered under Medicaid (see Beal v. Doe, 432 U.S. 438, 444 [1977]), federal regulations require that that any such service "must be sufficient in amount, duration, and scope to reasonably achieve its purpose". 42 C.F.R. § 440.230(b).

It has been held in Vermont and in most other jurisdictions that any restrictions placed by the state on an otherwise covered medical service must be based on "medical necessity". Such a service must be "distributed in a manner which bears a rational relationship to the underlying federal purpose of providing the service to those in the greatest need

of it". Brisson v. Dept. of Social Welfare, 167 Vt. 148, 151 (1997); White v. Beal, 413 F.Supp. 1141, 1151 (E.D.Pa. 1976).

In defining dental services the Department has adopted the federal definition found at 42 C.F.R. §§ 440.100 and 440.120(b): "Dental services are preventive, diagnostic, or corrective procedures and artificial structures involving oral cavity and teeth". MM § M621.1. It is presumed that the primary medical basis for dentures is to chew food (certainly the Department has not proffered any other medical reason for providing coverage for dentures). However, the regulations make no mention of this medical need as a basis for coverage. If a recipient needs full dentures for this purpose, she gets them. If she needs a partial denture for the exact same purpose, she doesn't.

In this case, the petitioner has no posterior lower teeth. The evidence amply demonstrates that the petitioner's medical need for a partial denture (i.e., the need to be able to chew her food) is just as severe as it would be if she were seeking a full denture. A partial denture fully meets the definition of an "artificial structure involving . . . teeth" contained in M621.1, supra. If there is a valid *medical* distinction between the petitioner's need for a partial

denture and another recipient's need for a full denture the Department has not said what it is.[4]

In a case virtually identical on its facts to this one the Appeals Court of Indiana held that a state cannot arbitrarily exclude from Medicaid coverage a medically necessary item such as a partial denture that meets the state or federal definition of coverage under the category of dental services. Coleman v. Indiana Family and Social Services Administration, 687 N.E.2d 366 (Ind.App. 1977). The Coleman Court specifically distinguished its holding from the case of Anderson v. Director, Dept of Social Services, 300 N.W.2d 921 (Mich.App. 1981) cited by the Department in its arguments in this matter. In Anderson, the Appeals Court of Michigan upheld regulations in that state that barred Medicaid coverage for root canals and for partial dentures to replace single teeth. There, as here, the state's primary rationale for the regulations was cost containment. However the Court in that case upheld the regulations because the state showed that extraction of a single *diseased* tooth was a medically reasonable alternative to a root canal and far less costly for recipients; and it held that limiting partial dentures to

[4] The Department's assertion that recipients can also seek partial dentures primarily for cosmetic reasons clearly doesn't apply to this petitioner.

cases where a person's chewing ability was substantially impaired was reasonably based on medical necessity.

In this case, neither the petitioner's situation nor the state regulations are anything like the facts in Anderson. Here, there is no dispute that the petitioner's chewing ability is fully impaired. Moreover, her remaining teeth (all anterior) are perfectly healthy. The Department admits that its regulations do not provide the petitioner with a reasonable medical alternative to correct her problem[5], only one that is medically extreme, if not dangerous--i.e. the extraction of healthy teeth in order to accommodate a full denture. This clearly distinguishes the case from Anderson and from other cases in which limitations on coverage *based on medical necessity* have been upheld. See e.g., Cowan v. Myers, 187 Cal.App.3d 968, 232 Cal.Rptr. 299 (1986), *cert. denied,* 484 U.S. 846, 108 S.Ct. 140, 98 L.Ed. 97 (1987). Court decisions in this and other jurisdictions have consistently held that Medicaid coverage limitations based on cost effectiveness without regard to the medical needs of recipients are contrary to the federal requirements regarding amount, duration, and scope. See Brisson, 167 Vt. at 152.

[5] See Commissioner's **M108 Request Decision**, #8.

The irrationality of the Department's position becomes even more apparent when this petitioner's circumstances and choices are examined in more detail. As noted above, if the petitioner were to have her remaining healthy teeth surgically extracted and be fitted for a full denture, this would be covered under the Department's regulations, solely because the Department has apparently determined that in most cases this would be less expensive than providing a partial denture. However, the uncontroverted evidence in this matter shows that this petitioner's dentist is willing to provide a partial denture for the same cost as a full denture, and that the petitioner is unlikely to lose any more teeth. Nonetheless, the regulations require the petitioner to either go without dentures entirely or submit to the "option" of a completely unnecessary and potentially dangerous surgical procedure. In Brisson, the Vermont Supreme Court noted that in failing to provide a recipient with a certain medical service (in that case a CCTV reading device), if the alternatives are more costly and potentially medically detrimental to the recipient, the Department "cannot credibly maintain that coverage is too expensive . . ." Id. at 152.

In defending its position in this matter the Department once again--as it did in Dutton v. Dept. of Social Welfare,

168 Vt. 281 (1998), and in the recently decided Fair Hearing No. 16,414—relies primarily on the legal argument that its regulation is dictated, and thus legitimized, by a directive from the state legislature. However as was noted by the Court in Dutton and by the Board in Fair Hearing No. 16,414, this fact is "not significant" in determining the validity of a Medicaid regulation--"[i]f the state regulations are in conflict with federal law, the fact that they are consistent with state law would not remedy this problem." Dutton, 168 Vt. at 285.

Certainly, neither the legislature nor the Department can be faulted, as a general matter, for attempting to maintain the admittedly difficult balance between providing as many medical benefits as possible to recipients while controlling program costs. The law is clear, however, that regardless of fiscal considerations, restrictions on Medicaid coverage cannot be medically arbitrary. This hardly means, however, that the Department has no choice but to furnish partial dentures to everyone who wants them. Department need look no further than its own regulations for examples of dental service limitations based on thoughtful and legitimate assessments of medical need. The regulations and policies regarding orthodontic treatment for individuals under age 21,

which are the subject of many fair hearings, but which the Board has invariably upheld, come immediately to mind. See MM § M622 et seq.

The Department need also look no further than its own memorandum in this matter for an example of valid limitations on the coverage of partial dentures. In its citation to the Anderson case (see supra), the Department notes that the State of Michigan provides partial dentures only "when there are less than six back teeth in bite or at least four front teeth in one arch missing". (See Anderson, 300 N.W.2d at 923.) This regulatory establishment of a *legitimate* medical necessity evaluation is precisely why the limitations in Michigan were upheld in Anderson. Thus, although cited by the Department in this matter as support for its position, the Anderson decision actually elucidates why the Department's limitations in M621.6, which lack such an evaluation, cannot be upheld.

The above notwithstanding, neither this decision nor the Anderson and Coleman cases hold that the Department must allow Medicaid coverage for partial dentures whenever it can be shown that a recipient can't chew. The prior approval process could still be used to determine whether further tooth loss is likely and, thus, whether the surgical removal of teeth and

the fitting of a full denture is a *medically legitimate* cost-effective treatment option for a recipient.

It is clear, however, that Medicaid recipients like the petitioner, who cannot chew due to the absence of posterior upper or lower teeth, and who are not facing the likelihood of further loss of existing teeth, have a *medical* need for dentures that is identical to recipients who require full dentures. Therefore, it cannot be concluded that the Department's regulations regarding dentures are sufficient in amount, duration, and scope to achieve their purpose, which is to provide recipients with a means to chew. To the extent that the provisions of M621.6 impose a *blanket* exclusion of Medicaid coverage for medically necessary partial posterior dentures, they impermissibly conflict with federal regulations and are, therefore, invalid. For these reasons the Department's decision in this matter is reversed.[6]

# # #

[6] It is unnecessary to consider the petitioner's additional argument that disallowing coverage for partial dentures for adults, while allowing it for children, is impermissibly discriminatory. It can be noted, however, that providing expanded dental coverage to children appears to be a legitimate "age-appropriate" distinction under federal law. Compare, e.g., Selgado v. Kirschner, 878 P.2d 659 (Ariz. 1994) (regulations allowing life saving organ transplants only for children are contrary to federal law).